The State Board of Medicine's Resolution of Complaints Against Physicians and Physician Assistants

October 1999

Report 99-02

Office of Performance Evaluations
700 W. State Street, Lower Level, Suite 10
P.O. Box 83720, Boise, Idaho 83720-0055

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Office of Performance Evaluations
Idaho State Legislature

Joe R. Williams Building
Lower Level, Suite 10
P.O. Box 83720
Boise, Idaho 83720-0055
(208) 334-3880
FAX (208) 334-3871

Nancy Van Maren
Director

September 14, 1999

Members, Joint Legislative Oversight Committee
Idaho State Legislature

At the direction of the Joint Legislative Oversight Committee, we have conducted an evaluation of the State Board of Medicine's resolution of complaints against physicians and physician assistants. Interest in this evaluation centered around concerns about the board's handling of complaints against physicians, the fairness of the process for the public and licensees, and the sufficiency of board resources to investigate and discipline licensees.

I respectfully submit our completed evaluation for your review and consideration. We recommend the board adopt guidelines to ensure a formal and consistent process for investigating and resolving complaints. The staff's consistency in case investigation has relied upon the knowledge of a few experienced staff, making it vulnerable to the exercise of individual judgment and staff turnover. We also recommend the board increase the frequency and content of its communication with complainants. Board communication with complainants has been inadequate to provide assurance that complaints have been adequately investigated and, at times, has been misleading.

Further, should policymakers wish to more clearly specify the circumstances in which case information may be released, Idaho Code and rule would require revision. Presently, the law gives the board substantial discretion to exempt from public disclosure proceedings and information related to complaint investigation and resolution. As a result, the information the board releases could change by case, over time, and with staff turnover. We also conclude that, although current board resources are sufficient to carry out complaint-related responsibilities, given dramatic increases in the cost of complaint resolution—largely due to increases in legal expenses—license fee levels should be monitored for sufficiency in the future.

Throughout this evaluation, we received the full cooperation of the Board of Medicine and its staff. This report was written and researched by Eric Milstead (lead), George Gorsuch, Jim Henderson, Bev Nicholson, and Rosemary Curtin (contractor), with the assistance of other Office of Performance Evaluations staff.

Sincerely,

Nancy Van Maren

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The State Board of Medicine's Resolution of Complaints Against Physicians and Physician Assistants

Executive Summary

In November 1998, at the request of the Joint Legislative Oversight Committee, we began a performance evaluation of the discipline process of certain licensees under the Idaho State Board of Medicine. The Idaho House of Representatives Health and Welfare Committee requested this evaluation, in part, due to questions that had arisen regarding the Board of Medicine's handling of complaints against practicing physicians, and questions whether the board's resources were sufficient to adequately investigate and discipline physicians and physician assistants licensed by the board. Questions were also raised as to whether the board's process for reviewing complaints was fair to both the public and licensees.

We reviewed the board's processes for investigating and resolving complaints against physicians and physician assistants.

To conduct this report, we asked:

- How and by whom may complaints be filed with the Board of Medicine and what role do complainants play in the process? What process does the Board of Professional Discipline follow to review complaints and what guidelines govern the process?
- How and to what extent does the Board of Professional Discipline communicate with complainants and respondent licensees?
- What information regarding complaints is publicly available? Is public membership on the Boards of Medicine and Professional Discipline adequate? How does the Board of Medicine make the public aware of matters involving licensee discipline?
- What sanctions may the Board of Professional Discipline impose in discipline cases and how frequently has it done so?

- How long has it taken to resolve complaints?
- Are Board of Medicine resources sufficient to adequately and effectively investigate complaints?

Methods

The Board of Medicine administers the Medical Practice Act, the purpose of which is to assure public health, safety, and welfare through the licensure and regulation of physicians.

To conduct our review, we:

- Reviewed Idaho Code, administrative rules, and relevant Board of Professional Discipline meeting minutes.
- Interviewed members of both boards and board staff on matters pertaining to the agency's operations.
- Analyzed electronic case tracking data maintained by the board; reviewed case files selected to be representative of both "typical" cases and those with high public profile and reviewed record keeping systems related to those cases.
- Obtained comparative information from medical boards in four other states in the region; interviewed staff from medical boards in three other states that were reported to be particularly effective at case resolution and/or communication; and interviewed administrators of nine physician profiling systems in other states.
- Obtained comparative information from the Federation of State Medical Boards and reviewed state medical board Internet web sites.

Background

The Board of Medicine delegates physician discipline to the Board of Professional Discipline.

Among other statutory responsibilities, the Board of Medicine is charged with administering the Medical Practice Act, the purpose of which is to assure the public health, safety, and welfare through the licensure and regulation of physicians. As part of this charge, the board licenses medical doctors, doctors of osteopathy, and physician assistants, among others. The Board of Medicine delegates to the Board of Professional Discipline its related authority to investigate and decide complaints that allege that physicians or physician assistants have violated the Medical Practice Act. The process of case investigation and resolution is complex and involves several stages. The process is detailed in Chapter 1.

Board of Professional Discipline Case Resolution

Between January 1990 and December 1998, the Board of Professional Discipline resolved cases in an average of 150 days, although a few cases took much longer.

Between 1990 and 1998, the board opened and closed 783 cases in an average of 150 days per case. We found that while about three-quarters of all cases were resolved in less than 150 days, a few cases (about 30) remained open more than four times as long. After accounting for these cases, which include those that the board kept open to monitor rather than investigate, the average resolution period for cases dropped to 112 days.

Over the last three years, the Board of Professional Discipline has taken disciplinary action at a rate generally in line with medical boards in four other states in the region.

During 1990–1998, the board took disciplinary action in 26 percent of all cases opened.

In resolving a case, the board may take disciplinary action against a licensee ranging from reprimanding a licensee to revoking his or her license. During 1990–1998, the board took disciplinary action in 203 (26 percent) of 783 cases. Nearly 40 percent of these actions were confidential admonishments—notifications to the licensee that the board has concerns with some aspect of the licensee's actions related to a complaint. Thirty-one percent of the actions were stipulations and orders—the placement of a specified condition on the license to practice.

During 1996–1998, the board took disciplinary action at an average rate of 9.5 actions per 1,000 licensees. This rate was higher than three of the four states for which we have comparison rates. Only Oregon had a higher rate of discipline, at 10.7 actions per 1,000 licensees, during this period.

Over the last three years, the board's rate of discipline has been higher than three of four states we reviewed.

While the Board of Professional Discipline's process for investigating and resolving complaints appears to have been consistently followed, this consistency has been based largely upon staff's personal knowledge and experience, leaving the process vulnerable to individual judgment and turnover.

Despite a wide variety in types and sources of cases, board staff have been consistent in their investigation process.

Our review of complaint case files indicated that, despite a broad variation in types of cases and sources of complaint—each of which require slightly different treatment—board staff had been consistent in their process for investigating cases. Each of the case files we reviewed contained acknowledgment of complaint receipt, documentation of investigation, documentation of case resolution, and notification of complainants and respondents when the case was resolved.

However, we found that personal knowledge and experience rather than written guidelines or procedures have accounted for consistency in investigation. Without guidelines providing the board's direction, the staff relies upon their own experience to make decisions throughout the many stages of the process. Given a heavy reliance on personal experience, the process is vulnerable to staff turnover. On the other hand, four of five boards we surveyed have implemented written guidelines to govern their process. Consequently, to provide assurance of consistency, we recommend the board develop written guidelines to govern the complaint investigation and resolution process.

The Board of Medicine's electronic record keeping system contained a number of data entry errors, omissions, and coding inconsistencies, limiting the quality of information it generated.

The accuracy of the board's case tracking database could be improved.

Board staff maintain a case tracking database that serves as the key source of data for case status, timeliness of case resolution, and disciplinary actions taken. However, the database contained several errors and omissions that resulted in inaccurate reports on cases and disciplinary action. Board staff made needed adjustments, and attributed many of the errors to inexperienced staff. In light of the importance of this data, we recommend that board staff limit access to the database, provide sufficient training to select and appropriate staff, and regularly enter and verify case data.

Board staff consistently and timely informed complainants and respondents of complaints received and board actions taken. However, the information provided complainants was otherwise inadequate and potentially misleading.

Each case file we reviewed included notification to the complainant and respondent that the complaint had been received. Each of the files of cases that had been resolved also included notice to the complainant and respondent of case resolution. Furthermore, board staff communicated with complainants and respondents within a reasonable period of time. In the files we reviewed, respondents were notified within an average of 6 days after complaint resolution. Complainants were notified within an average of 12 days of complaint receipt and within an average 6 days of case closure.

Each case file we reviewed documented timely notification about complaint receipt and case resolution.

However, the board's communication with complainants was otherwise inadequate and potentially misleading. For example, when a case had been closed with no action, board staff sent a form letter stating that the facts of the case did not warrant disciplinary action or, simply, that the case had been closed. The letter did not state how a case was investigated or resolved or even whether an investigation was conducted. In addition, when the board took confidential disciplinary action, staff sent the complainant a letter stating that "it was determined that the facts do not appear to warrant medical disciplinary action." A complainant could be misled that no action was taken, when, in fact, some confidential action did occur.

Finally, citing concerns about case confidentiality, the board does not communicate with complainants during the course of an investigation, even though this may mean several months without information. Absent more frequent and informative communication, the complainant may conclude that the complaint was not adequately investigated. Consequently, we recommend the Board of Professional Discipline increase the information it provides to complainants and consider updating complainants periodically during investigations, within the bounds of confidentiality.

The board should provide more detailed and frequent information to complainants.

The Board of Medicine has substantial discretion through Idaho Code and administrative rule to determine what information is exempt from public disclosure.

While provisions in both the Medical Practice Act and the Public Records Act establish an expectation that information will be open and public, other provisions within the same acts and administrative rule give the board substantial discretion in

exempting information from public disclosure. In making its decisions, the board has relied upon legal counsel to determine the status of information; in turn, counsel has relied upon Idaho Code, which allows the board significant discretion. Otherwise, there are no written guidelines that the board follows to ensure consistency in decisions about confidentiality. Yet without them, decisions about the information that may be released could change by case, over time, and with staff turnover. This, in turn, could create a perception that the board is inconsistent in the information it releases in each case. Consequently, should policymakers wish to more clearly specify board discretion, relevant Idaho Code sections and administrative rule would require revision.

Legal fees have accounted for much of the growth in board expenditures.

Cost of Complaint Investigation and Resolution

Over the past four years, the cost of resolving discipline cases has increased significantly, largely due to rising legal expenses.

Although the board's cash reserves are projected to decline some, recent fee increases should help to counter cost increases.

The cost of resolving discipline cases doubled during 1996–1999, increasing from about $2,400 per case in fiscal year 1996 to about $4,800 per case in fiscal year 1999. Much of this increase may be attributed to rising legal expenses; average legal costs per case rose from $1,165 in fiscal year 1996 to $5,411 in fiscal year 1999, an increase of about 365 percent. Just as some cases took much longer than average to resolve, a small number of cases incurred much higher than average legal fees.

At present, the Board of Medicine appears to have sufficient resources to carry out its complaint-related responsibilities, although ongoing monitoring of revenues and expenditures is advisable.

The number of full-time positions allocated to complaint investigation increased from 2 in fiscal year 1996 to 3.75 in fiscal year 1999. At the same time, the board's overall appropriation per license has increased steadily since fiscal year 1995. Also, during the 1999 legislative session, the board received approval to increase fees to help defray the growing costs of case investigation and resolution. Despite this fee increase, the board's cash reserves are projected to decline in fiscal year 2000, and could decline further if cost trends continue. We suggest the board closely monitor revenues and expenditures and seek

adjustment to licensing fees as necessary to meet the rising costs of case investigation and resolution.

Public Awareness and Participation in Board of Medicine Complaint Resolution Process

The Board of Medicine provides little or no public outreach or education, limiting public awareness of its role in investigating and resolving complaints about licensees.

Related to its charge to administer the Medical Practice Act, the Board of Medicine provides the public with information about its role in regulating and disciplining licensees, including certain information about disciplinary action taken. However, the board's efforts to ensure the public is aware of its complaint investigation and resolution functions are limited to producing an annual newsletter, answering requests for information, and listing its local and toll-free telephone number in telephone directories. Other states we surveyed did more in this regard, including requiring all physicians' offices to post placards advertising the medical board and how to make contact. Many states publish information on Internet web sites advertising their role, methods to contact them, and how to file a complaint. Without further public outreach, members of the public may be unaware of resources that are available should physician misconduct occur. As a result, we recommend the Board of Medicine create a plan for improving public outreach and education about its role in licensee discipline.

Public confidence in the board might be strengthened with additional public outreach.

The Patient Freedom of Information Act will increase publicly available information about health care providers, but may be only moderately effective in achieving its goal.

The Patient Freedom of Information Act, enacted in 1998, gives the Board of Medicine additional responsibilities to provide the public with information about lawsuits and other actions against health care providers who are licensed by the board. Although the Act will increase the publicly available information about health care providers, it has weak enforcement provisions and may be only moderately effective in producing useful information to consumers about health care providers' practice histories. The act relies on self-reporting and provides penalties for non-compliance

The Patient Freedom of Information Act relies on licensee self-reporting and has weak enforcement provisions.

that are weak relative to other profiling systems we reviewed. Should policymakers wish to strengthen Idaho's health care provider profiling system, the statutory provisions for verification of reported data, sources of data, and board enforcement authority should be reviewed.

Public membership on the Boards of Medicine and Professional Discipline is about average for boards nationally.

Public membership requirements for Idaho's Board of Medicine are typical of those nationally.

We assessed the level of public involvement in the discipline case resolution process as indicated by public membership on the Boards of Medicine and Professional Discipline. By law, both boards have 20 percent of their positions filled by members of the public, compared to an average of 22 percent nationally.

Two states have recently recommended increasing public membership to make the boards more effective and increase public confidence in the disciplinary process. However, given discipline rates in recent years, it does not appear that Idaho's board requires such a move at this time.

Summary of Report Findings and Recommendations

1. While about three-quarters of all cases were resolved in less than 150 days, a few cases remained open more than four times as long. *Page 16*.

2. After accounting for those cases taking much longer than typical, the average resolution period for cases during 1990–1998 was 112 days. *Page 17*.

3. Approximately 26 percent of all cases that were opened and closed during 1990–1998 resulted in some disciplinary action. *Page 20*.

4. Over the last three calendar years, Idaho's Board of Professional Discipline took disciplinary action at a rate generally in line with four other states in the region. *Page 20*.

5. Board staff appeared to have been consistent in the practices they followed to resolve cases. *Page 25*.

6. Staff's personal knowledge and experience rather than written guidelines or procedures have accounted for consistency in the investigation of board cases. *Page 25*.

7. Four of five boards we surveyed had written guidelines for the complaint resolution process. *Page 25*.

    - **We recommend the Board of Professional Discipline develop written guidelines to govern the complaint investigation and resolution process.** *Page 26*.

8. Board staff had not consistently entered and maintained data in their case tracking database, limiting the quality of information it generated. *Page 26*.

- **We recommend that Board of Medicine staff limit access to the discipline database, provide sufficient training to those who are charged with its maintenance, and regularly enter and verify case data.** *Page 27.*

9. Board staff consistently informed respondents of complaints that had been received and board actions taken, and did so within reasonable periods of time. *Page 27.*

10. The Board of Professional Discipline consistently notified the complainant when a complaint had been received and when it was resolved, and did so within reasonable periods of time. *Page 28.*

11. The Board of Professional Discipline's communication with complainants was otherwise inadequate and potentially misleading as a result of the board's concern with case confidentiality. *Page 28.*

    - **We recommend the Board of Professional Discipline increase the information it provides to complainants and consider updating complainants periodically during investigations, within the bounds of confidentiality.** *Page 29.*

12. Idaho Code and administrative rule provide substantial discretion to the Board of Medicine to determine what information may be disclosed to complainants and to the general public. *Page 29.*

    - **Should policymakers wish to more clearly specify the board's discretion in releasing case information, relevant Idaho Code sections and administrative rules would require revision.** *Page 31.*

13. The average cost of investigating and resolving a case doubled between fiscal years 1996 and 1999. *Page 33.*

14. Legal costs associated with case resolution have increased at a faster rate than agency personnel and non-legal operating costs. *Page 34.*

15. The Board of Medicine appears currently to have sufficient resources to carry out its complaint-related responsibilities. *Page 36.*

16. The Board of Medicine's fund reserves are currently adequate, but are projected to decline in fiscal year 2000, even with anticipated increases in revenue. *Page 38*.

17. The enforcement mechanisms in Idaho's Patient Freedom of Information Act are weak relative to those in similar laws in other states. *Page 42*.

18. Idaho's Patient Freedom of Information Act may be only moderately effective in producing useful information for the public about health care providers' practice histories. *Page 44*.

    - **Should policymakers wish to strengthen Idaho's health care provider profiling system, the statutory provisions for verification of reported data, sources of data, and board enforcement authority should be reviewed.** *Page 45*.

19. Although the Board of Medicine has developed educational materials about its operations related to licensee discipline, it otherwise takes few steps to inform the public about its role. *Page 45*.

20. Health regulatory boards in states we reviewed generally made stronger efforts to educate the general public about their role and the information they can provide about licensee discipline. *Page 46*.

    - **We recommend the Board of Medicine create a plan for improving public outreach and education about its role in licensee discipline.** *Page 47*.

21. The number of public members on the Boards of Medicine and Professional Discipline by law is about average for medical boards nationally. *Page 48*.

22. The terms of the public members on the Board of Medicine end simultaneously, which may not ensure continuity of public representation. *Page 49*.

Introduction
Chapter 1

In November 1998, at the request of the Joint Legislative Oversight Committee, we began a performance evaluation of the discipline process of certain licensees under the Idaho Board of Medicine. The Idaho House of Representatives Health and Welfare Committee requested this evaluation, in part, due to concerns that had arisen regarding the Board of Medicine's handling of complaints against practicing physicians, and questions whether the board's resources were sufficient to adequately investigate and discipline licensees. Questions were also raised as to whether the board's process for reviewing complaints was fair to both the public and licensees. Our review covered both the Board of Medicine, inasmuch as it is the responsible body under Idaho Code, and the Board of Professional Discipline, a separate board created by the Board of Medicine to which it has delegated the discipline of licensed medical doctors, doctors of osteopathy, and physician assistants.[1]

We evaluated the Board of Medicine's process for disciplining certain licensees, such as physicians.

To conduct our evaluation, we asked:

- How and by whom may complaints about physicians and physician assistants be filed with the Board of Medicine? What role does the complainant play in the process once the complaint has been filed?

- What process does the Board of Professional Discipline follow to review complaints? What guidelines govern the complaint resolution process? How may complainants appeal board decisions?

- How and to what extent does the Board of Professional Discipline communicate with respondent licensees?

Concerns had arisen about the board's complaint handling process and the sufficiency of resources.

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[1] Hereafter, we use "licensee" to denote these licensees that the Board of Professional Discipline may discipline.

We looked at the rate of disciplinary sanctions, the cost to investigate cases, and the timeliness of case resolution.

- What information about complaint investigation and resolution is available to the public? When does this information become public? How does the Board of Medicine make the public aware of matters involving licensee discipline?
- What sanctions may the Board of Professional Discipline impose when a licensee violates governing statutes? How frequently has each sanction been applied during the last nine years?
- How long, on average, has it taken to resolve complaints since 1990?
- Are Board of Medicine resources sufficient to adequately and effectively investigate complaints?
- How well is the public represented in the physician discipline process, as indicated by public membership on the Boards of Medicine and Professional Discipline?

We did not consult medical experts or otherwise attempt to evaluate board action on a given case.

Given the direction received from the Oversight Committee, we did not consult with medical experts or attempt other means to evaluate whether the board's resolutions to complaints were appropriate.

Evaluation Approach and Methods

To answer these questions, we:

- Reviewed Idaho Code, administrative rules, and the minutes of the Board of Professional Discipline's meetings from 1990 through 1998;
- Interviewed members of both boards and board staff on matters pertaining to the agency's operations;
- Analyzed electronic case tracking data maintained by the board for cases opened during 1990–1998;
- Reviewed case files selected to be representative of both "typical" cases opened during 1990–1998 and those with high

public profile, and reviewed recordkeeping systems related to those cases;

- Obtained comparative information from boards of medicine in four other states in the region;
- Interviewed staff from boards of medicine in three other states that were reported to be particularly effective at resolving discipline cases and/or communicating case outcomes, and interviewed administrators of nine physician profiling systems in other states;
- Gathered comparative information from the Federation of State Medical Boards, where possible;
- Reviewed state medical board Internet web sites, where available, in each state.

We relied primarily on data for cases opened and closed during 1990–1998.

Overall, we conclude that the Board of Medicine and agency management has ensured a systematic process of investigation and resolution of complaints. Case investigations were generally adequately documented. Also, three-quarters of cases were resolved within 150 days, although after accounting for a small percentage of cases that took much longer than typical, the average resolution period for cases during 1990–1998 was 112 days. Finally, we found that board communication with respondents was reasonably timely and adequate.

Overall, board staff have followed a systematic process of complaint investigation and resolution.

However, we found areas where the Board of Medicine and the Board of Professional Discipline could improve operations. While board staff appeared to have consistently investigated the cases we reviewed, this consistency relied heavily on the knowledge of a few experienced staff rather than written guidelines. As a result, staff have not had formal direction from the board (through guidelines) to follow in investigating cases, and the investigation process is vulnerable to the exercise of individual judgment and staff turnover. Also, the board's communication with complainants is inadequate to provide assurance that complaints have been adequately investigated. Further, the board's electronic system for tracking cases included a number of errors and omissions that limit the value of reports on the board's work.

However, improvements are needed in other areas.

The board appears to currently have sufficient personnel and budgetary resources to carry out its complaint-related

Resources are presently sufficient, but should be monitored, in light of recent cost increases.

responsibilities, although, in light of the increasing costs of resolving complaints, the board's fund balance and level of license fees should be monitored. We also learned that statute and administrative rule provide the board significant discretion in exempting from public disclosure proceedings and information related to the complaint investigation and resolution function. Finally, the board's efforts to ensure the public is aware of its complaint investigation and resolution functions are limited and could be improved.

The Board of Medicine

A number of legal provisions govern and direct the operations of the Board of Medicine. Figure 1.1 summarizes the major provisions of Idaho Medical Practice Act and the Disabled Physician Act. Overall, the Board of Medicine is charged with

Figure 1.1: Principal Statutory Responsibilities of the Board of Medicine

The Idaho Medical Practice Act creates and authorizes the Board of Medicine to regulate physicians and other health care providers. The purpose of the act is to assure public health, safety, and welfare by licensure and regulation of physicians (Idaho Code § 54-1802).

To carry out this purpose, the board is authorized to:

- Establish rules and regulations for administration of the Medical Practice Act.
- Create a Board of Professional Discipline to enforce and supervise professional discipline under the act. The Board of Professional Discipline is authorized to conduct disciplinary investigations, hold hearings, and impose disciplinary sanctions.
- Determine qualifications for physician and physician assistant licensure and administer the licensing of physicians.
- Investigate allegations of unlicensed medical practice.
- Hire staff to conduct business of the Board of Medicine.
- Investigate, pursuant to the Disabled Physician Act, alleged licensee substance or alcohol abuse.
- Submit budgetary information.

Source: IDAHO CODE §§ 54-1801–1808, 54-1831–1841 (1998).

administering the Medical Practice Act, the purpose of which is to assure the public health, safety, and welfare through the licensure and regulation of physicians.[2]

As part of this charge, the board licenses medical doctors, doctors of osteopathy, and physician assistants, among others. Table 1.1 shows the number of medical doctors, doctors of osteopathy, and physician assistants that the board licensed each year from 1994 through 1999. During this period, the total number of licensed physicians and physician assistants increased 22 percent, from about 3,000 in 1994 to 3,665 in 1999. During the same period, Idaho's population grew 8 percent.

The Board of Medicine delegates to the Board of Professional Discipline the discipline of medical doctors, doctors of osteopathy, and physician assistants.

Complaint Investigation and Resolution Process

Idaho Code authorizes the Board of Medicine to create a Board of Professional Discipline and delegate to it the responsibility for enforcing and supervising professional discipline of these licensees.[3] As Figure 1.2 shows, the process of considering and rendering professional discipline involves many stages. The

The process of resolving complaints involves a number of decision points.

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[2] IDAHO CODE § 54-1803, -1808 (1998).

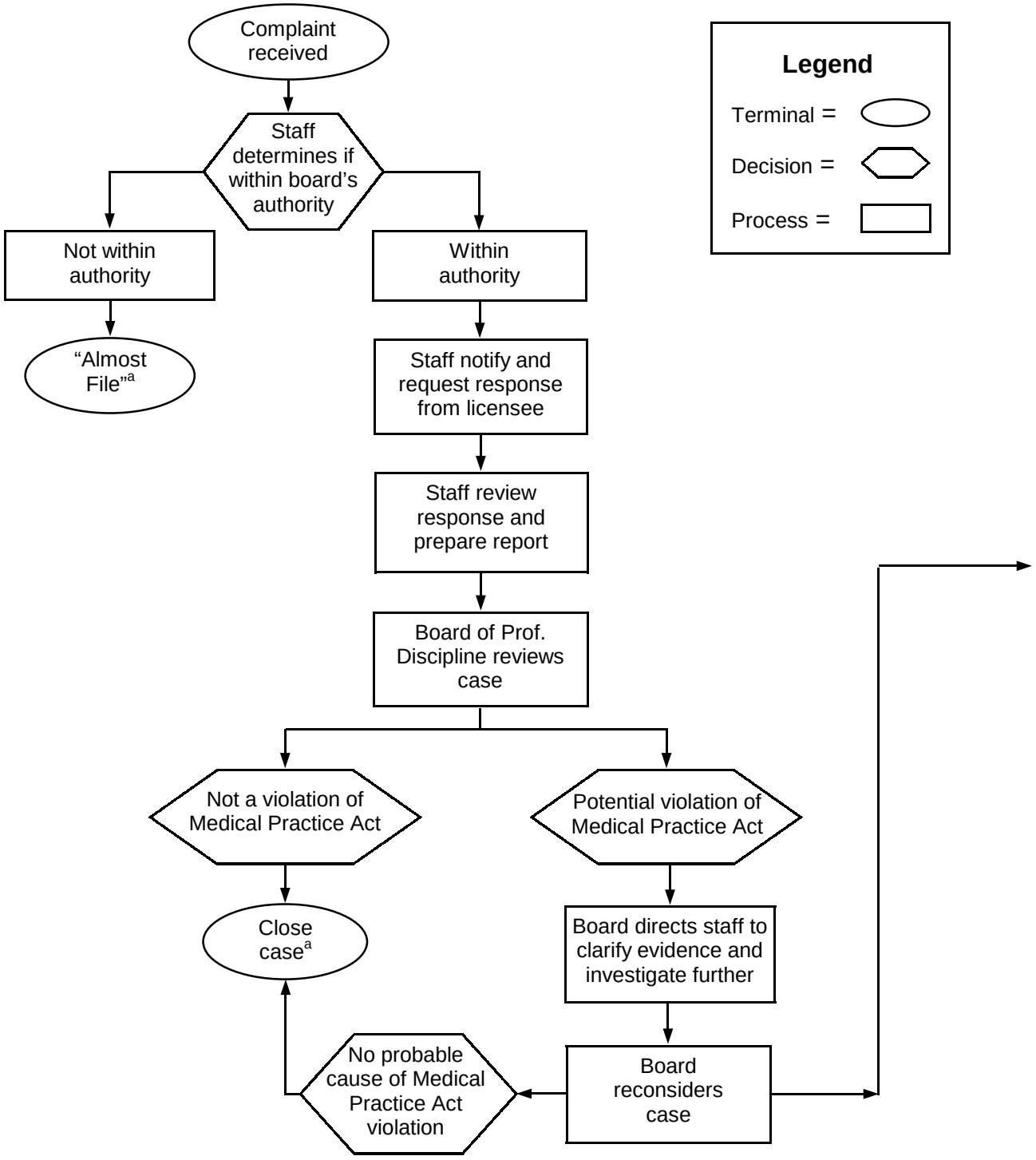
[3] IDAHO CODE § 54-1806A (1998). The Board of Professional Discipline is prohibited from acting in connection with physician licensing except as it relates to ongoing disciplinary action. However, it is authorized to investigate complaints regarding licensees and may, when warranted, enter orders affecting the license itself. The Board of Medicine retains disciplinary responsibility for a number of other health care providers, including athletic trainers and physical therapists.

Table 1.1: Number of Selected Board of Medicine Licensees, Fiscal Years 1994–1999

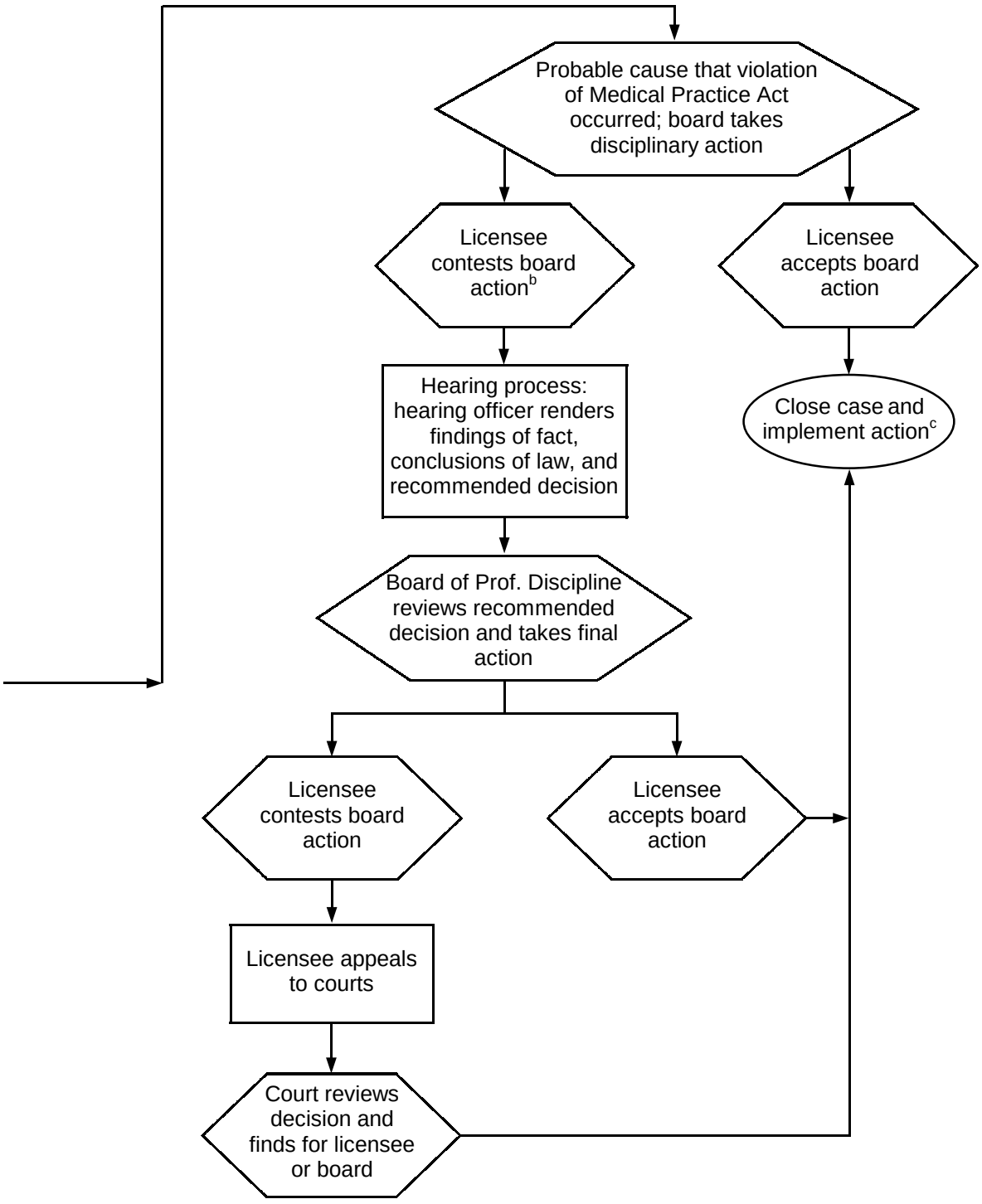
License Type	1994	1995	1996	1997	1998	1999
Medical Doctor	2,791	2,907	3,062	3,177	3,341	3,343
Doctor of Osteopathy	125	132	136	154	168	170
Physician Assistant	78	94	104	129	149	152
Total	2,994	3,133	3,302	3,460	3,658	3,665

Source: Board of Medicine licensee reports.

Figure 1.2: General Representation of the Complaint Investigation and Resolution Process



[a] Respondents and complainants are notified of the board action when a case is closed.



[b] At any point during the process of resolving a respondent's challenge of a board action, an agreement to settle may be reached.

[c] Board staff monitors all cases closed with disciplinary action to ensure compliance.

The Board of Professional Discipline receives complaints from the public, health care professionals, hospitals, medical associations, or managed care organizations.

process begins when a complaint is received. Complaints may be received from members of the public, other health care professionals, and health care organizations, such as hospitals, medical associations, and managed care organizations. The Board of Professional Discipline may also begin an investigation on its own initiative. Typically, the board does so when it has received information from national databanks indicating concerns that warrant investigation.

At times, board staff receive complaints that do not fall within the board's jurisdiction. In these cases, staff refer the complainant to the appropriate authority, or, in cases in which the complainant is seeking monetary damages, inform the complainant of the alternative process that must be followed.[4]

Once staff determine a complaint is within the board's jurisdiction, they notify the complainant and the subject of the complaint (the respondent) that the complaint has been received. Staff also ask the respondent to respond to the allegation and provide the appropriate documents, such as medical records related to the complaint. The respondent may face disciplinary proceedings for refusing to comply with the board's request for records.

Board staff notify the complainant and the respondent when a complaint has been received.

After receiving and reviewing the initial information, staff summarize for the board the current complaint, evidence collected, the respondent's response to notification about the complaint, and any prior cases filed against the respondent. The board reviews this information to determine whether there has been a violation of the Medical Practice Act. The case is closed without discipline if the board determines that no violation occurred, or may be closed with discipline if the board determines a violation occurred (see discussion below). However, if the board determines a violation *may* have occurred, it may request further investigation. At this point, a consultant—typically an unpaid physician—may be asked to review medical records and evaluate the appropriateness of care provided.

If the board determines that a violation of the Medical Practice Act took place, the board may discipline the respondent. Idaho

[4] Those seeking financial damages are required to go through the pre-litigation screening process before they can file a malpractice claim. Board of Medicine staff are responsible for administering this process.

Code specifies the disciplinary actions the board may use. As shown in Figure 1.3, these actions range from imposing a fine to suspending or revoking a license. Further, disciplinary actions may be either formal or informal. Informal discipline is confidential under Idaho Code and may include a letter of concern, reprimand, or admonishment.[5] Formal discipline, however, is not confidential under Idaho Code. It may include the placement of restrictions or conditions on the license, suspension or revocation of license, requirements for additional education, or the imposition of fines.

The board may take disciplinary action ranging from a confidential letter of concern to license revocation.

If the respondent chooses to contest the board's disciplinary action, the board may proceed with a formal hearing.[6] At the completion of the hearing, the hearing officer renders findings of fact and conclusions of law and recommends disciplinary action to be taken. The respondent either accepts the disciplinary action or requests reconsideration of the case. Such a request can be denied or result in a modification to the first decision rendered.

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[5] Reprimands are exempt from disclosure according to IDAHO CODE § 9-340 (3)(k) (1998) and not reported to the National Practitioner Data Bank or the Federation of State Medical Boards' action database.

[6] Disciplinary hearings are governed by IDAHO CODE § 54-1806A(8) (1998) and the *Administrative Procedure Act*, IDAHO CODE § 67-5240 (1998).

Figure 1.3: Disciplinary Actions Available to the Board of Professional Discipline

- Revoke licensee's license;
- Suspend or restrict licensee's license;
- Impose conditions or probation upon license;
- Impose administrative fine on licensee up to $10,000;
- Assess costs and attorney's fees for investigation and/or administrative proceeding against licensee;
- Temporarily suspend or restrict licensee's license without a hearing;
- Reprimand licensee by informal admonition;
- Accept licensee's resignation and surrender of license.

Source: IDAHO CODE § 54-1806A (1998).

Following the board's decision on the request for reconsideration, the respondent may appeal the board's decision to district court. In addition to its responsibilities related to licensee discipline, under new legislation that takes effect January 1, 2000 (the Patient Freedom of Information Act), the Board of Medicine has the additional responsibilities related to providing the public with health care provider profiles. This act is discussed in Chapter 4.

Board Membership

Seven board members are licensed physicians, two are public members, and one is the director of the Department of Law Enforcement.

Members of the two boards serve three- or six-year terms and their membership may overlap. The Governor appoints nine of ten members of the Board of Medicine, including seven licensed physicians (six medical doctors and one osteopath) and two public members.[7] Physicians serve six-year terms and public members serve three-year terms.[8] The director of the Department of Law Enforcement also serves on the board by law.

The Board of Professional Discipline is comprised of five members appointed by the Board of Medicine: four licensed physicians and one public member. Members serve three-year terms and may be reappointed. According to board staff, the practice has been for the Chairman and Vice-Chairman of the Board of Medicine to sit also on the Board of Professional Discipline. Although not the case at present, each Board of Professional Discipline member also could be a member of the Board of Medicine.

Budget and Staffing

The Board of Medicine's annual appropriation has increased each year since 1995.

The Board of Medicine's activities are funded by license and registration fees.[9] Table 1.2 shows the board's appropriations, including supplemental appropriations, for fiscal years 1995 through 2000, and comparison figures for the state's General Fund. As shown, the board's appropriation has increased each year since 1995. By comparison, the state's General Fund appropriations also increased each year, although at a lower rate every year but 1995.

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[7] IDAHO CODE § 54-1805 (1998).
[8] Idaho Code is silent on the reappointment of members.
[9] IDAHO CODE § 54-1808 (1998).

Table 1.2: Increases in Board of Medicine Appropriations, as Compared to the General Fund, Fiscal Years 1995–2000

Fiscal Year	Board of Medicine Appropriation	Change From Previous Fiscal Year	Appropriations	Change in General Fund From Previous Fiscal Year
1995	$ 495,500	+13%	$1,268,128,600	+15.5%
1996	560,600[a]	+13	1,343,254,800[a]	+5.9
1997	627,200[a]	+12	1,423,084,100[a]	+5.9
1998	747,000[a]	+19	1,460,996,800[a]	+2.7
1999	865,100	+16	1,619,738,200	+11.0
2000	1,187,900	+37	–	–

[a] Includes supplemental appropriations received.

Source: Office of Performance Evaluations analysis of 1993–1999 Idaho Sess. Laws and Idaho Legislative budget books.

Similarly, board staffing levels have increased since fiscal year 1995. In 1995, the board had authority for eight full-time positions (FTPs). For fiscal year 1998, the board was given an additional FTP, another in fiscal year 1999, and two more for fiscal year 2000. At present, the board has authority for a total of 12 FTPs.

The Board of Medicine employs a licensed nurse as a full-time executive director. The Executive Director and Associate Director are responsible for the agency's administrative functions and other duties assigned by the board. Two quality assurance specialists are responsible for the day-to-day process of investigating complaints against licensees. Other board staff assist in investigating and resolving complaints to a lesser extent.

Two quality assurance specialists are primarily responsible for investigating complaints.

Sources of Information for Licensee Discipline

To aid in regulating and disciplining licensees, the Board of Medicine receives information about adverse actions taken against physicians, such as disciplinary actions, reductions in hospital privileges, and medical malpractice claims from a number of sources. It also provides information about

disciplinary action it has taken toward licensees to the national data banks listed below and to other states in which licensees are likely to maintain dual licensure.

The Board of Medicine reports disciplinary actions it has taken to national databanks, which, in turn, provide information about prospective licensees.

- The National Practitioner Data Bank and the Healthcare Improvement and Protection Data Bank contain the disciplinary histories of health care providers, medical malpractice payments, criminal convictions, and civil judgments related to medical practice. Hospitals, other health care facilities, malpractice insurance companies, medical boards, and others are required to submit information to the data banks with a copy of the information going to the regulatory board in the state in which the adverse action occurs.[10] Additionally, Board of Medicine staff search the data bank on every application for licensure. Board staff may also refer to data bank information when investigating a discipline case.

- Among other services, the Federation of State Medical Boards provides member boards with monthly reports of disciplinary actions taken by all member medical boards in other states. The Federation operates as a clearinghouse of information to member boards, providing guidance on licensing and discipline issues.[11]

- The Idaho Board of Pharmacy refers to the Board of Medicine allegations received that physicians are violating prescribing law under the Controlled Substances Act.

- Other states' medical boards, such as those in Washington and Oregon, communicate with Idaho's Board of Medicine directly regarding disciplinary actions taken against physicians who maintain dual licensure in both states.

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[10] *Health Care Quality Improvement Act of 1986*, U.S.C. § 11101 (1998).

[11] For example, the federation maintains a model Medical Practice Act and a model structure for the modern medical board to provide state boards with examples of current trends in the regulation of medical practice.

The Board of Professional Discipline Case Resolution
Chapter 2

We reviewed the Board of Professional Discipline's process for resolving complaints filed with the Board of Medicine regarding medical doctors, doctors of osteopathy, and physician assistants. We focused on four aspects of the process: (1) the timeliness with which complaints have been handled; (2) the number of disciplinary actions that have been taken; (3) the consistency with which the process has been carried out; and (4) how well the Board of Professional Discipline has communicated with those who have brought the complaints (complainants) and with licensees who are the subject of complaints (respondents). We did not use outside medical experts or attempt other means to evaluate whether the board's resolutions to specific complaints were appropriate.

We focused on four aspects of the complaint resolution process: timeliness, disciplinary action, consistency, and communication.

Our review showed few problems with the rate of disciplinary actions taken in comparison with other states in the region. We found that three-quarters of complaint cases were resolved in less than 150 days, and, after accounting for cases that took much longer than typical, the average resolution period was 112 days. In addition, complaints appeared to have been consistently investigated. Respondents were generally notified on a timely basis of the allegations filed against them and given reasonable time to respond to allegations. However, the process rests heavily on the knowledge of a few experienced staff rather than established written guidelines. As a result, staff have not had formal direction from the board (through guidelines) to follow in investigating cases, and the investigation process is vulnerable to the exercise of individual judgment and staff turnover. Also, we conclude that the board should increase information provided to complainants and improve the quality of information in the database it uses to track cases.

We did not consult medical experts or otherwise attempt to evaluate board action on a given case.

Board of Professional Discipline Cases

Complaints outside the board's jurisdiction are kept for future reference, but are not investigated.

To understand the Board of Professional Discipline's complaint investigation and resolution process, we interviewed board staff and reviewed related documentation. Board staff receives complaints from members of the public, health care providers, and health care organizations.[1] When staff determine that the substance of a complaint would be covered under the Medical Practice Act, they open a case file, assign a case number, and begin an investigation.

If staff determines a complaint does not fall within the board's authority to review, it is not opened as a case nor investigated. For example, a complaint concerning insurance coverage of medical care provided by a physician is not within the board's jurisdiction, and consequently, would not be opened as a case for investigation.[2] Instead, board staff respond to these and hold them in a separate file for future reference called the "Almost File." In 1998, 50 of 156 complaints received were determined to be outside the board's statutory authority to review, and were held in the Almost File.

From 1990–1998, board staff opened 862 complaint cases, an average of 96 cases annually.

Between January 1990 and December 1998, board staff opened a total of 862 cases. On average, 96 cases were opened each year. As Figure 2.1 shows, the number of new cases in a year increased noticeably in 1993 and since that time has remained relatively steady.

Timeliness of Complaint Resolution

Effective and responsive complaint resolution processes help ensure timely case investigation and resolution. Some states have mandated maximum case resolution time frames, largely to ensure their boards remain responsive to complainants and respondents.[3] While the Idaho State Board of Medicine is not statutorily required to resolve cases within an established time frame, timely case resolution remains an important public service.

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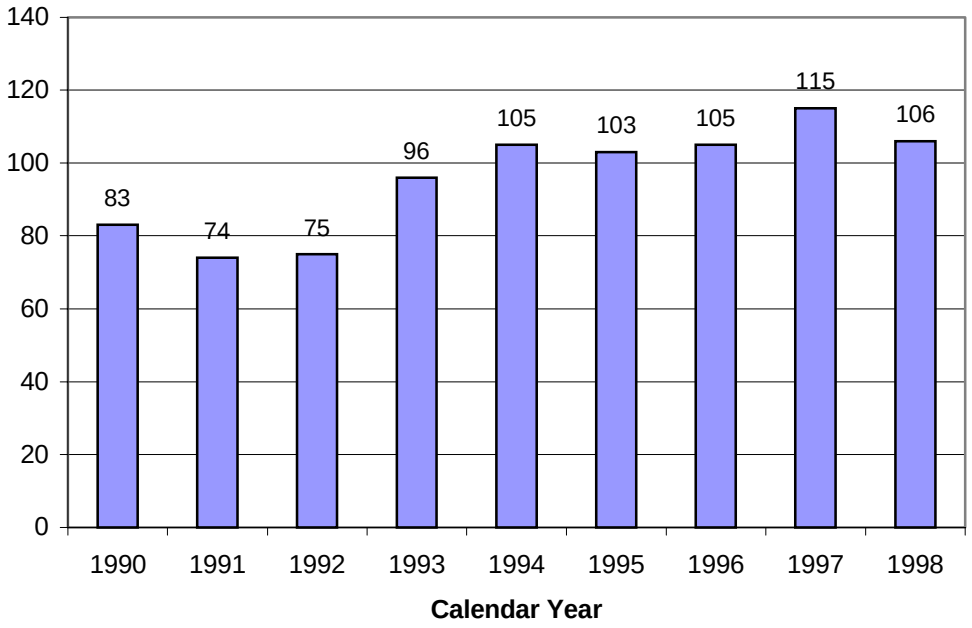
[1] Health care professionals are required to report potential violations of IDAHO CODE § 54-1814 of the Idaho Medical Practice Act. Health care organizations are required to report "adverse actions," such as reductions in hospital clinical privileges, under the *Health Care Quality Improvement Act of 1986*, 42 U.S.C. § 11101 (1998).

[2] IDAHO CODE § 54-1814 (1998).

[3] Maryland and Michigan each place statutory limits on time that may be taken to resolve a case.

Figure 2.1: Number of Cases Opened, Calendar Years 1990–1998



Total number of cases opened 1990–1998 = 862

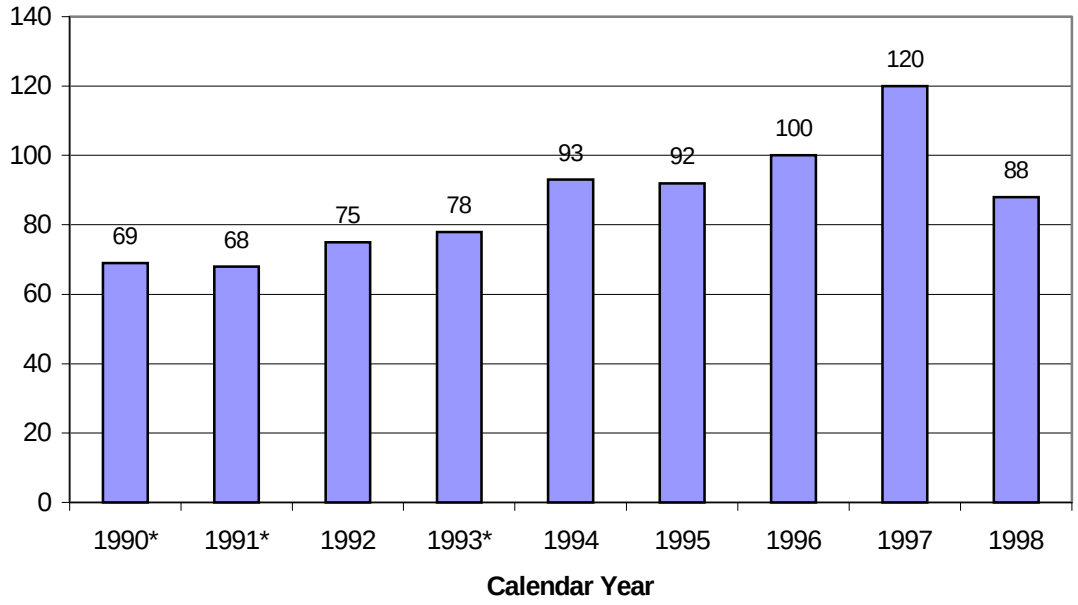
Source: Office of Performance Evaluations analysis of Board of Medicine discipline database.

We looked at the number of cases the board closed each year during 1990–1998. Of the 862 cases opened during this period, 783 had been closed by the end of 1998, and 14 remained open. Figure 2.2 shows the number of these cases that were closed each year. Note that some cases are not opened and resolved in the same calendar year. Furthermore, the figures for 1990 through 1993 do not include 17 cases the board closed in these years that were opened in the 1980s.

To assess complaint resolution timeliness, we measured the days elapsed between complaint receipt and final case resolution.

To assess the board's timeliness in resolving complaint cases, we measured the days elapsed between complaint receipt and final case resolution for those cases opened and closed during 1990–1998. As Table 2.1 shows, during this period, cases were resolved in an average of 150 days. However, the average case resolution times shown were lower in 1990–1993 than those for subsequent years, in part because they do not reflect resolution times for longer-term cases opened during the 1980s (which would have brought up the average). Table 2.1 also shows that

Figure 2.2: Number of Cases Opened and Closed, Calendar Years 1990–1998



Total number of cases closed 1990–1998 = 783

* Note that the board resolved an additional 15 cases in 1990, 1 case in 1991, and 1 case in 1993 that were each opened prior to 1990.

Source: Office of Performance Evaluations analysis of Board of Medicine discipline database.

the average number of days for case resolution increased significantly (37 percent) in 1995, again in 1997 (25 percent), and more recently leveled off in 1998.

During 1990–1998, cases were resolved in an average of 150 days.

To look at case resolution time more closely, we plotted the number of days taken to resolve each of the 783 cases that were opened and closed during 1990–1998 and grouped them into 50-day increments. We found:

- **While about three-quarters of all cases were resolved in less than 150 days, a few cases remained open more than four times as long.**

Table 2.2 shows the distribution of all case resolution times for cases opened and closed during 1990–1998. As shown, more than half (423 cases or 54 percent) of all cases were resolved

Table 2.1: Average Days Between Complaint Receipt and Case Resolution for Cases Opened and Closed, Calendar Years 1990–1998

Year	Average Number of Days	Percent of Change From Previous Year
1990	70	–
1991	83	–[a]
1992	102	–[a]
1993	117	–[a]
1994	117	0%
1995	160	+37%
1996	178	+11%
1997	222	+25%
1998	226	+2%
Overall average	150	

[a] Percent not calculated due to time lag in resolving cases opened in 1980s.

Source: Office of Performance Evaluations analysis of Board of Medicine database.

Over half of all cases were resolved within 100

within the first 100 days. Three-quarters (601 cases or 77 percent) were resolved within 150 days. On the other hand, 12 percent of (93 cases) took over 250 days to resolve and about 5 percent (37 cases) took over 500 days to resolve.

We found:

- **After accounting for those cases taking much longer than typical, the average resolution period for cases during 1990–1998 was 112 days.**

A few lengthy cases caused an increase in the overall average resolution period.

During the period reviewed, 37 cases (5 percent) took longer than 500 days to resolve. These cases included, among others, those in

Table 2.2: Case Resolution Times by Number and Percent of Cases Opened and Closed, Calendar Years 1990–1998

Days	Number of Cases	Percent of Total	Cumulative Percent
0-50	142	18%	18%
51-100	281	36	54
101-150	178	23	77
151-200	56	7	84
201-250	33	4	88
251-300	25	3	91
301-350	8	1	92
351-400	11	1	93
401-450	5	1	94
451-500	7	1	95
501-550	1	0	95
551-600	6	1	96
601-650	1	0	96
Over 650	29	4	100

N = 783
Average = 150 Median = 94

Source: Office of Performance Evaluations analysis of Board of Medicine discipline database.

Case monitoring, rather than investigation, accounted for some of the lengthy resolution periods.

which respondents appealed board decisions to district court. Cases were left open during the appeal process, although staff did not actively work on them during the appeal process. The cases also included those in which the board required a respondent to be monitored for a specified period without disciplinary action. These cases were also left open during the monitoring period. According to staff, in one case, monitoring accounted for five years of the total case resolution period.

Some of the variation in resolution time can be seen by looking at average resolution time for each type of case. Table 2.3 shows the 783 cases opened and closed during 1990–1998 by type (as categorized by board staff) and the average time for case resolution for each type. While cases were resolved in an average of 150 days overall, some types tended to be resolved in less than

Table 2.3: Average Number of Days for Case Resolution by Type of Complaint for Cases Opened and Closed, Calendar Years 1990–1998

Type of Complaint Allegation	Number of Cases	Percent of Total	Average Days Between Complaint Receipt and Case Closure
Standard of care	370	47%	135
Improper conduct	139	18%	113
Rx narcotics	57	7%	273
Improper sexual behavior	33	4%	251
Fees[a]	32	4%	106
Ethics	25	3%	122
Alcohol impairment	17	2%	216
Drug impairment	16	2%	173
Denial of care	13	2%	65
Crime	12	1%	150
Records	10	1%	166
Other impairment	10	1%	346
Competency	9	1%	114
Disability evaluation	7	1%	61
Abandonment	3	–	111
Supervision	2	–	182
Other[b]	28	4%	183
Total	783	Overall average	150

[a] The board does not have the statutory authority to discipline a physician regarding fees. However, because fee disputes often overlap with other grounds for discipline, board staff created a complaint category for fees.
[b] Includes cases staff determined were not suitable to categorize in the defined type, such as reciprocal information, exceeded practice authority, and inadequate training.

Source: Office of Performance Evaluations analysis of Board of Medicine discipline database.

average time (e.g., fee disputes, allegations of improper conduct, etc.), and other types averaged much longer (e.g., allegations of sexual misconduct and inappropriate use of narcotics).

Board Disciplinary Actions Taken

Disciplinary action taken during 1990–1998 ranged from reprimanding a licensee to revoking a license.

We examined how frequently the board took disciplinary action in cases opened and closed during 1990–1998. We found:

- **Approximately 26 percent of all cases that were opened and closed during 1990–1998 resulted in some disciplinary action.**

As noted, during 1990–1998, the board opened and closed 783 cases. As Table 2.4 shows, in 203 of these cases (26 percent), the board took some sort of disciplinary action. Conversely, in 580 cases (74 percent) the board resolved the case without taking disciplinary action.

Confidential letters of admonishment made up 39 percent of all disciplinary actions taken during 1990–1998.

Table 2.5 lists the type of disciplinary action taken and the percent of disciplined cases in which each action was taken. As shown, disciplinary action ranged from reprimanding a licensee to revoking a license. In 39 percent of all disciplined cases the licensee received an admonishment. In these cases, the board resolved the case with a confidential letter to the respondent expressing its concern with the circumstances of the case. In 31 percent of all disciplined cases, the board issued a stipulation and order, specifically limiting the medical license in some way. In a small percentage of all disciplined cases, the licensee either surrendered his or her license (4 percent) or it was revoked or suspended (4 and 5 percent respectively).

We compared the frequency of the board's disciplinary actions with five boards in four states in the region.[4] To standardize the measurement across states, we calculated a rate of discipline based on the number of disciplinary actions per 1,000 licensees issued by the state medical board. We found:

- **Over the last three calendar years, Idaho's Board of Professional Discipline took disciplinary action at a rate generally in line with four other states in the region.**

[4] National data was unavailable for a more complete comparison.

Table 2.4: Board of Professional Discipline Actions Taken on Cases Opened and Closed, Calendar Years 1990–1998

	Number of Actions	Percent of Total
Discipline Actions		
Admonishment[a]	80	10%
Examination required	3	–
License revoked	9	1
License surrendered	9	1
License suspended	11	1
Put on probation	1	–
Reprimanded[b]	16	2
Stipulation and order issued[c]	62	8
Other	12	2
Total	203	25%
Non-Discipline Actions		
Case closed without discipline	564	72%
Referral to another agency	9	1
Other[e]	7	1
Total	580	74%
Grand Total	**783**	**100%**[d]

[a] A confidential notification of concern with the circumstances of the case.
[b] A reprimand for the circumstances of the case.
[c] Puts a specified condition on a license to practice medicine in Idaho.
[d] Does not sum due to rounding.
[e] Includes cases flagged to indicate remaining concerns and denials of license based on discipline.

Source: Office of Performance Evaluations analysis of Board of Medicine discipline database.

Table 2.5: Discipline Actions Taken by Type on Cases Opened and Closed, Calendar Years 1990–1998

Discipline Action	Number of Actions	Percent of Total
Admonishment[a]	80	39%
Examination required	3	2
License revoked	9	4
License surrendered	9	4
License suspended	11	5
Put on probation	1	–
Reprimanded[b]	16	8
Stipulation and order issued[c]	62	31
Other[d]	12	6
Total	203	100%[e]

[a] A confidential notification of concern with the circumstances of the case.
[b] A reprimand for the circumstances of the case.
[c] Puts a specified condition on a license to practice medicine in Idaho.
[d] Includes cases flagged for future review and denials of license based on discipline.
[e] Does not sum due to rounding.

Source: Office of Performance Evaluations analysis of Board of Medicine discipline database.

The board's rate of discipline during 1990–1998 was generally in line with that of comparison states.

As Table 2.6 shows, during 1996–1998, Idaho took 9.47 disciplinary actions per 1,000 licensees. While this rate fell below Oregon's rate of 10.7 per 1,000 licensees, it exceeded the rates for the other three states that provided figures.[5] While such a comparison does not provide an assessment of whether the board's actions were warranted in individual cases, it does provide some indication of Idaho's level of discipline relative to other states.

[5] Each state's board had roughly comparable jurisdictions.

Table 2.6: Average Disciplinary Actions per 1,000 Licensees, by State, Calendar Years 1996–1998

	Average Number of Disciplinary Actions per 1,000 Licensees
Idaho	9.5
North Dakota	5.5
Oregon	10.7
Washington (medical board)	5.4
Washington (osteopathy board)	5.1
Wyoming	6.2

Source: Office of Performance Evaluations survey of states in the region.

Procedures for Investigating Complaints

As described in Chapter 1, the Board of Professional Discipline's complaint resolution process is complex. This complexity is due, in part, to variation in the type of complaints the board receives. Figure 2.3 shows 16 categories board staff use to define complaint types, each of which may warrant different resolution procedures. For example, in cases alleging sexual misconduct by a licensee, the board may not provide the respondent a copy of the complaint letter in order to protect case confidentiality. In other cases, such as those alleging poor quality of care, the board may request that an expert consultant review and evaluate the medical records concerning the care provided.

The board's complaint resolution process varies, in part, due to complaint type and complaint source.

The variation in complaint source also adds complexity to the process for resolving complaints. For example, board staff respond differently when a complaint is received by a member of the public (notification is sent) than when the complaint originates from the National Practitioner Data Bank or another health care provider (no notification is provided).

Appeals of board decisions also add to the complexity of the process. Board staff are involved in responding to and preparing for each level of appeal allowed under Idaho Code including board reconsideration and court appeal.

Figure 2.3: Complaint Types as Categorized by Board Staff

Complaint Type	General Description
Fees	Disputes between physician and patients regarding fees charged for medical care.
Standard of care	Quality of medical care provided by physician falls below community standards.
Competency	Physician has diminished capacity to provide quality medical care.
Rx narcotics	Physician did not follow established practices when prescribing drugs.
Crime	Physician was convicted of crime.
Records	Physician failed to follow established practices in managing patient records.
Denial of care	Physician inappropriately denied care to a patient.
Disability evaluation	Physician failed to appropriately evaluate a patient's disability.
Improper sexual behavior	Health care provider exhibited improper sexual behavior toward patient.
Improper conduct	Health care provider displayed improper conduct toward patient.
Abandonment	Physician established care for, then abandoned, patient.
Ethics	Physician failed to adhere to standards of conduct established by the community.
Supervision	Physician failed to supervise other health care providers after delegating authority for providing medical care.
Alcohol impairment	Health care provider is impaired due to the use or abuse of alcohol.
Drug impairment	Health care provider is impaired due to the use or abuse of drugs.
Other impairment	Health care provider is impaired due to mental illness.

Source: Descriptions provided by Board of Medicine staff.

We reviewed board procedures for opening and investigating cases within this complex process. We found:

- **Board staff appeared to have been consistent in the practices they followed to resolve cases.**

We reviewed 20 randomly-selected case files and 13 selected files to review the process board staff followed to resolve cases. Despite the variation in types of cases and sources of complaints, case documentation indicated that board staff had been consistent in their process for investigating cases. Each of the case files we reviewed contained acknowledgment of complaint receipt.[6] Documentation of investigation was also present in all the files we reviewed, including a copy of the letter to the respondent requesting a response to the allegation and submission of the required medical records. In each of the cases that had been resolved, documentation of case resolution and notification of the complainant and respondent were present.

Investigations were documented in every case file we reviewed.

However, we found:

- **Staff's personal knowledge and experience rather than written guidelines or procedures have accounted for consistency in the investigation of board cases.**

Staff told us they did not follow written guidelines, but relied on past experience to make the needed decisions about how to open and investigate a case. Also, staff told us there were no procedures to guide case documentation; they documented cases according to their past experiences.

Staff relies on experience to open, investigate, and document cases.

In contrast, we found:

- **Four of five boards we surveyed had written guidelines for the complaint resolution process.**

Of the state boards we surveyed, those in North Dakota, Wyoming, and both in Washington indicated they had guidelines in place to aid staff with various decisions on each case. In Washington, case investigation and documentation guidelines are in statute. These statutory guidelines provide the board's

Other states rely on written guidelines to make decisions throughout case investigation.

[6] Thirteen of the cases were publicly initiated, which requires complaint acknowledgment.

direction to staff as to the appropriate use of discretion and identify factors to be used by the board in determining disciplinary action.

Written guidelines would help assure complainants and respondents of a consistent investigation process.

Although Idaho State Board of Medicine staff appear to have followed consistent investigation practices in the cases reviewed, the board has not provided formal direction in the terms of written guidelines to direct the investigation process. In addition, given staff's heavy reliance on personal experience, there is no assurance of consistency in complaint investigation in the future, particularly if there is turnover in the most experienced staff. Formal, written guidelines would provide assurance to complainants and respondents of the process to be followed, and lessen the impact of any future loss of experienced staff. Therefore:

We recommend the Board of Professional Discipline develop written guidelines to govern the complaint investigation and resolution process.

Electronic Record Keeping System

The board's case tracking database is the key source of data for case status, timeliness of case resolution, and disciplinary actions taken. It is the source the board uses to generate statistical and descriptive reports. However, during the course of our review, we found:

The board's complaint tracking system had a number of data entry errors and internal coding inconsis-tencies.

- **Board staff had not consistently entered and maintained data in their case tracking database, limiting the quality of information it generated.**

The board's case tracking system contained a number of data entry errors, omissions, and coding inconsistencies. For example, of the 783 cases opened and closed during 1990–1998, 69 cases (9 percent) that had been resolved as early as 1995 were not shown as closed; 528 cases (67 percent) had no complaint source (e.g. patient, doctor, health care facility) listed; and 72 (9 percent) did not list the grounds for the complaint.

When specific errors were pointed out, board staff corrected the data as necessary.[7] Board staff explained that several of the errors

[7] We used the more complete data for analysis in this report. Figures cited are accurate as of June 16, 1999.

were data entry errors by inexperienced staff. However, many of the errors had gone undetected due to a lack of oversight. Yet, without accurate case tracking data, board staff are not able to accurately report to the board, the Governor, Legislature, and others that rely on this statistical information when making policy, budget, and discipline decisions. Inaccuracies can also lead to confusion about case status and an inability to readily identify licensee histories. Therefore:

System oversight should be improved to increase the quality of case data.

We recommend that Board of Medicine staff limit access to the discipline database, provide sufficient training to those who are charged with its maintenance, and regularly enter and verify case data.

Communication With Respondents

During the course of our review, concerns arose about the board's communication with respondents. We reviewed the board's communication with respondents in 20 randomly selected case files and 13 files of cases with some degree of public visibility. We found that in the cases we reviewed:

We reviewed the board's communication with respondents in randomly selected cases and in cases with a degree of public notoriety.

- **Board staff consistently informed respondents of complaints that had been received and board actions taken, and did so within reasonable periods of time.**

Each case file we reviewed included a letter from the Board of Professional Discipline, notifying the respondent that a complaint had been received and attaching a copy of the formal complaint.[8] Furthermore, each of the files we reviewed that had been closed included a letter notifying the respondent of board action. For the randomly selected cases, this letter was dated, on average, six days after that action was taken; in the selected cases, the board appears to have responded within a similar time frame.

The content and timeliness of the board's communication with respondents appeared reasonable.

In addition, board staff appeared to allow respondents the time needed to respond to the board's initial inquiries. Of the randomly selected files, the board made an inquiry of the respondent within an average of 14 days after receiving the

[8] Exceptions were made in cases: (1) involving alleged sexual misconduct; in these cases, the board did not provide the respondent a copy of the complaint; and (2) initiated by the board; in these cases, the respondent was often notified after the initial investigation was complete.

complaint, and respondents responded within an average of 30 days after notification. Board staff sent a second inquiry in an average of 49 days after its initial inquiry, when a response had not yet been received.

Communication With Complainants

This evaluation was undertaken, in part, to respond to concerns that the board had not been responsive to complainants. We examined correspondence between the board and complainants in 20 randomly selected case files, each of which began with a complaint by a member of the public.[9] We found that in the cases we reviewed:

The board acknowledged receipt of a complaint within an average of 12 days after receipt.

- **The Board of Professional Discipline consistently notified the complainant when a complaint had been received and when it was resolved, and did so within reasonable periods of time.**

Each case file we reviewed included a copy of a letter to the complainant acknowledging receipt of the complaint and stating that the complaint would be presented to the Board of Professional Discipline for review. On average, these letters were mailed 12 days after receipt of the complaint. In addition, each of the cases we reviewed that had been closed included a copy of a letter informing the complainant that the board had closed the case. Each letter was mailed an average of 6 days after the case was closed.

However, board communication with complainants was inadequate and, at times, misleading.

Although notices of complaint receipt and resolution were provided on a timely basis, we found:

- **The Board of Professional Discipline's communication with complainants was otherwise inadequate and potentially misleading as a result of the board's concern with case confidentiality.**

Board staff use form letters to communicate with complainants. When a case has been closed with no action, the board sends a

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[9] As noted previously, other complaints originate from sources such as physicians, the National Practitioners Databank, and the Federation of State Medical Boards.

letter stating that "the facts in the case do not warrant medical disciplinary action" or "[the] case [is] closed." However, the form letters do not disclose how a case was investigated or resolved, or even whether an investigation was conducted. Further, when the board takes disciplinary action it considers confidential, such as issuing a letter of concern, staff send the complainant a letter stating that "it was determined that the facts do not appear to warrant medical disciplinary action within the board's authority and it acted to close consideration of the matter." Also, citing concerns about case confidentiality, the board does not communicate with complainants during the course of an investigation, even though this may mean a period of several months during which the complainant may not know if an investigation is being conducted.

More in-depth or frequent communication from the board to complainants could provide assurance that the board is doing its job.

Without more in-depth or frequent communication, the complainant may conclude that his or her complaint was not investigated adequately, if at all. Increased communication within the bounds of confidentiality could improve the public's assurance that the board is adequately and appropriately responding to complaints.[10] Therefore:

We recommend the Board of Professional Discipline increase the information it provides to complainants and consider updating complainants periodically during investigations, within the bounds of confidentiality.

Disclosure of Complaint Case Information

To determine what information about a case was open to disclosure, we reviewed relevant statutes and administrative regulations. We found:

- **Idaho Code and administrative rule provide substantial discretion to the Board of Medicine to determine what information may be disclosed to complainants and to the general public.**

Three separate code provisions as well as agency rule govern the public status of board information.

Three separate sections of Idaho Code, the Idaho Medical Practice Act, the Idaho Medical Malpractice Act, the Public Records Act,

[10] In discussing our findings with board staff, they told us they intended to improve correspondence with complainants by more fully explaining steps the board has taken in investigating and resolving cases, to the extent allowed by confidentiality restrictions.

and Board of Medicine administrative rules together determine what case investigation information is available for public disclosure.[11]

Under these provisions, some information is to remain confidential.[12] For example, a confidential reprimand is expressly exempted from public disclosure, unless the respondent rejects the reprimand. In addition, the board is obligated to adhere to case settlement terms, including those requiring that information be kept confidential.

More broadly, however, while some statutory provisions establish an expectation that board records and proceedings will be open, other statutory sections and administrative rule allow the board a great deal of discretion in determining exemptions to the openness provisions. For example, language contained in both the Medical Practice Act and the Medical Malpractice Act creates an expectation that the board's records are subject to public disclosure:

Statutes create an expectation that all board records and proceedings will be public, but also give the board great discretion to protect information in any given case.

> "All papers, records, correspondence and proceedings of the Idaho state board of medicine shall be open and public except as otherwise provided in chapter 3, title 9, Idaho Code."[13]
>
> and
>
> "Proceedings...shall at all times be subject to disclosure according to chapter 3, title 9, Idaho Code;"[14]

At the same time, by statute and administrative rule, proceedings (including hearings) may be deemed exempt from public disclosure whenever the board, in the exercise of its discretion,

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[11] As discussed in Chapter 4, the Patient Freedom of Information Act creates a health care provider profiling system that may be accessed by the general public. Although this information will be self-reported, there exists the possibility that information may be available to the public through this new system while still being considered exempt from public disclosure by the Board of Medicine. This may create a conflict between the laws governing public records and the Patient Freedom of Information Act.

[12] IDAHO CODE §§ 9-340(3)(k), 54-1806A(6)(f) (1998); and IDAHO ADMIN. CODE, July 1, 1993, Vol. 6, IDAPA 22.01.07.32.

[13] IDAHO CODE § 54-1820 (1998).

[14] IDAHO CODE §§ 6-1001; 54-1806(8) (1998).

finds that the interest of justice or public health requires it to be kept confidential.[15] Furthermore, the Public Records Act states that, "unless otherwise provided by agency rule, information obtained as part of an inquiry into a person's fitness to…retain a license" is exempted from disclosure.[16] In turn, board rule opens some exemption decisions to the board's discretion.[17] Together, these rules and statutory provisions effectively allow investigatory records to be kept confidential at the discretion of the board.

In practice, the board makes available to the public disciplinary documents resulting from a formal hearing and adjudication, which may involve the revocation or suspension of a license, the imposition of conditions or probation, or an administrative fine.[18] However, statute allows the board to deem these same documents confidential at its discretion.[19]

To make these decisions, the board has relied on its long-term relationship with a contract attorney and long-term staff experience.[20] According to board staff, in making these decisions, counsel relies on statutory provisions, although these, as noted, allow substantial discretion. The board has not developed written guidelines to rely upon in the exercise of that discretion.

While board staff believe broad discretion is sufficient, variation by case may increase public concern with board operations.

Board staff explained that broad discretion was sufficient; they believe it would be difficult to more narrowly specify the situations in which records should be released. Yet, without guidelines to follow, decisions about the information or proceedings that may be released could change by case, over time, and with staff turnover. Variation by case and over time could create a perception that the board is inconsistent in determining what information may be released in each case.

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[15] IDAHO CODE § 54-1806A(8) (1998); and IDAHO ADMIN. CODE, July 1, 1993, Vol. 6, IDAPA 22.01.07.32.

[16] IDAHO CODE § 9-340(3)(I) (1998), and IDAHO ADMIN. CODE, July 1, 1993, Vol. 6, IDAPA 22.01.07.32.

[17] IDAHO ADMIN. CODE, July 1, 1993, Vol. 6, IDAPA 22.01.07.32. For example, informal admonitions.

[18] IDAHO CODE § 54-1806A (1998).

[19] IDAHO CODE § 9-340(3)(i) (1998).

[20] Board staff told us that they refer requests for information to their counsel for review.

In light of the lack of internal guidelines and concerns with public accountability for the consistency and appropriateness of board decisions:

Should policymakers wish to more clearly specify the board's discretion in releasing case information, relevant Idaho Code sections and administrative rules would require revision.

Costs of Complaint Investigation and Resolution
Chapter 3

Questions arose about the board's sufficiency of resources.

We reviewed the resources used by the Board of Medicine to investigate and resolve complaints to determine if they are sufficient. We found that although the number of cases closed each year remained fairly constant over the past four years, the cost of resolving discipline cases has increased significantly. Much of the cost increase can be attributed to rising legal expenses, which, according to board staff, reflect more vigorous challenges to the board's complaint investigation and resolution activities. The board has imposed fee increases to cover these costs, requesting and receiving budget supplementals and enhancements. These increases should provide the board sufficient resources to maintain current levels of service. However, the board's cash reserves are projected to decline in fiscal year 2000 and could decline further if cost trends continue. As a result, the board should monitor revenues and expenditures and seek adjustments to licensing fees as necessary.

Trends in the Costs of Complaint Investigation and Resolution

We estimated the board's costs for complaint investigation and resolution using expenditure information from the Statewide Accounting and Reporting System, and additional data provided by board staff. We found:

The average cost per case has doubled in the last three years.

- **The average cost of investigating and resolving a case doubled between fiscal years 1996 and 1999.**

As shown in Table 3.1, the total costs of investigating and resolving cases increased from approximately $225,000 in fiscal year 1996 to about $437,000 in fiscal year 1999, an increase of 94 percent. As a result, the average cost per case closed increased from about $2,400 in fiscal year 1996 to nearly $4,800 in fiscal year 1999.

Table 3.1: Complaint Case Investigation and Resolution Costs by Cost Type, Fiscal Years 1996–1999

Fiscal Year	Personnel Costs[a]	Legal Costs[b]	Other Costs[c]	Total Costs
1996	$ 103,347	$ 53,373	$ 67,844	$ 224,564
1997	135,835	90,247	91,038	317,120
1998	157,961	95,786	112,786	366,420
1999	145,522	155,235	135,828	436,585
Percent increase from FY 1996 to FY 1999	41%	191%	100%	94%

[a] Includes salaries and benefits of employees handling complaints.
[b] Includes attorney's fees, expenses for volunteer consultants (travel and similar expenses), court reporting, and hearing fees.
[c] Includes the costs of monitoring physicians in a substance abuse recovery program, plus allocations for utilities, office space, office supplies, and similar expenses. We allocated these costs based on personnel costs.

Source: Office of Performance Evaluations analysis of Board of Medicine legal costs reports and STARS database maintained by Idaho Legislative Services Office, Legislative Audits.

Rising legal costs are largely responsible for the increasing cost of resolving discipline cases.

Table 3.1 also shows the board's case resolution expenses categorized into personnel costs, legal costs, and other operating costs. We found:

- **Legal costs associated with case resolution have increased at a faster rate than agency personnel and non-legal operating costs.**

Personnel costs, legal costs, and other operating costs each increased from 1996 to 1999. However, as Table 3.1 shows, non-legal operating costs doubled during this period. Legal costs, including attorney's fees, court reporting fees, and costs of holding hearings, increased at over twice the overall rate, or about 191 percent. By comparison, personnel costs rose by about 41 percent.

Increases in legal fees indicate that the legal work involved in resolving a case, on average, has increased. Over the time period we reviewed, legal costs were incurred in 24 percent of cases closed. The percent of cases closed in a given year that incurred legal fees ranged from 16 percent in fiscal year 1997 to 30 percent in fiscal year 1996. Yet, according to board staff, the hourly rate

charged by the board's attorneys did not change during this period.

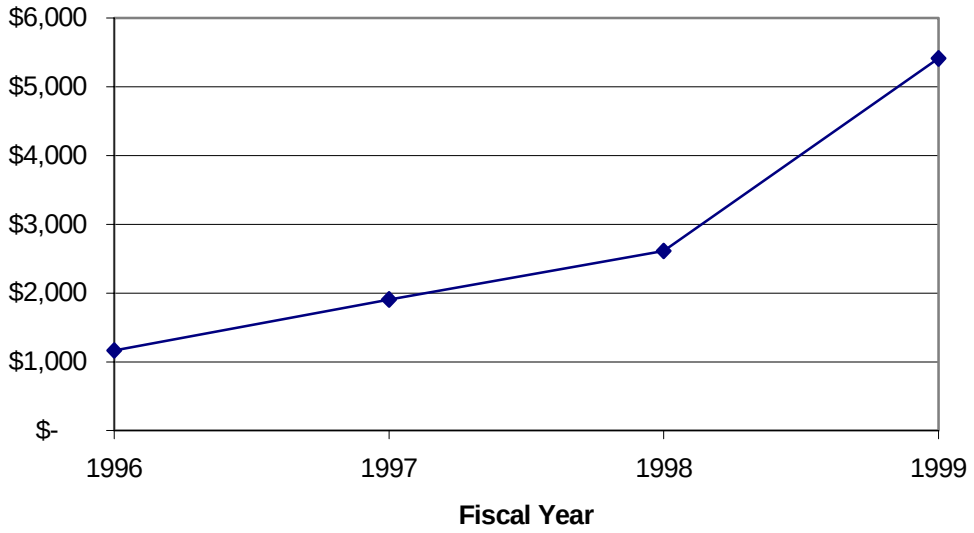
On average, legal costs more than tripled per resolved case.

As Figure 3.1 illustrates, for those cases in which legal expenses were incurred, average legal costs associated with resolving the case increased each year. Average legal costs per case increased from $1,165 in fiscal year 1996 to $5,411 (about 365 percent) in fiscal year 1999.

About one-quarter of all cases incurred the highest legal costs.

However, figures indicate that a few cases incur significantly greater legal expenses to resolve, increasing the overall average. While 75 of the 97 cases closed that incurred legal fees during fiscal year 1996–1999 (77 percent) incurred less than $1,000 each in legal fees, the remainder incurred considerably more. In one case, the board spent more than $80,000 in legal fees over six years.

Figure 3.1: Average Legal Costs per Resolved Case Incurring Legal Fees, Fiscal Years 1996–1999



Note: In some cases, legal costs were incurred during more than one fiscal year. To calculate the average cost per resolved case, we included only cases closed during a fiscal year and included all legal costs (including those incurred in prior fiscal years) associated with each case.

Source: Office of Performance Evaluations analysis of Board of Medicine legal expense data.

Budget and Staffing Resources

Board resources have increased to meet rising costs.

As noted, the Board of Medicine has received supplemental appropriations and budget enhancements (including increased staff) to meet its rising complaint investigation and resolution costs. We reviewed the board's budget and staffing for fiscal years 1995 through 1999 as compared to the number of licensed medical doctors, doctors of osteopathy, and physician assistants. Overall, we conclude:

- **The Board of Medicine appears currently to have sufficient resources to carry out its complaint-related responsibilities.**

Table 3.2 shows that the number of licensees per staff member peaked in fiscal year 1997, but has since declined with the addition of more staff. Also, the number of full-time positions allocated to complaint investigation rose from 2 in fiscal year 1996 to 3.75 in fiscal year 1999. The board's overall appropriation per licensee has increased steadily since fiscal year 1995.

Table 3.2: Board of Medicine Budget and Staff per Licensee, Fiscal Years 1995–1999

Fiscal Year	Number of Licensees	Full-Time Staff	Number of Licensees Per Staff Member[a]	Appropriation	Appropriation per Licensee
1995	3,133	8	391.6	$495,500	$158.16
1996	3,302	8	412.8	560,600[b]	169.78
1997	3,460	8	432.5	627,200[b]	181.27
1998	3,658	9	406.4	747,000[b]	204.21
1999	3,665	10	366.5	865,100	236.04

[a] Includes only licensed medical doctors, doctors of osteopathy, and physician assistants—those the Board of Professional Discipline may discipline.
[b] Includes supplemental appropriations received.

Source: Office of Performance Evaluations analysis of 1993–1999 Idaho Sess. Laws and Idaho Legislative budget books.

As Table 3.3 shows, since fiscal year 1996, the board has received about $73,600 in supplemental appropriations to cover case investigation and resolution costs.[1] Also, the board has received about $358,000 in budget enhancements and non-standard

[1] We included only those legal costs that could be allocated to complaint investigation and resolution, rather than other board activities, such as pre-litigation screening.

Table 3.3: Board of Medicine Complaint Resolution Budget Activity, Fiscal Years 1996–2000

Fiscal Year	Supplemental Appropriations		Enhancements, Non-Standard Adjustments, and Annualizations	
	Amount	Purpose	Amount	Purpose
2000	none to date		$83,700	One additional investigator and one additional clerical specialist
			42,000	Legal costs[a]
			25,000	Additional office space
			23,800	Annualization of additional investigator added in FY 1999
1999	$27,100	One additional investigator	15,991	Legal costs[b]
			13,700	Physicians' Recovery Network[c]
1998	28,670	Legal costs[b]	47,700	Medical investigator position
			23,968	Legal costs[b]
			6,500	Physicians' Recovery Network[c]
1997	17,836	Legal costs[b]	7,610	Legal costs[b]
			24,500	Physicians' Recovery Network[c]
1996	–		5,242	Legal costs[b]
			38,000	Physicians' Recovery Network[c]
Total	$73,606		$357,711	

[a] Enhancement requested to cover legal costs of complaint investigation and resolution, although some portion may cover other legal costs that will be incurred.

[b] Includes only the portion of enhancement or supplemental estimated to be allocated to complaint investigation and resolution.

[c] A substance abuse recovery program for physicians. The Board of Medicine incurs costs for monitoring enrolled physicians' progress and compliance with program requirements.

Source: Idaho Legislative Services Office, *Legislative Fiscal Report,* Fiscal Years 1996–2000 (Boise, 1995–1999).

adjustments for discipline purposes during this time. This represents slightly over half of all the board's supplementals and non-standard adjustments since fiscal year 1996.[2] As shown, many of the supplementals and enhancements related to discipline were requested to cover rising legal fees.

Despite increased revenue from a fee change, the board's fund balance is projected to decline.

Cash Reserves

During the 1999 legislative session, the board received approval to increase physician and physician assistant licensing fees to help defray the growing costs of complaint investigation and resolution. We estimate the board will receive additional revenues of approximately $280,000 from fee increases during fiscal year 2000. However, our analysis of the board's actual revenues, expenditures, and fund balances for fiscal years 1996 through 1999 and estimated revenues and expenditures for fiscal year 2000 revealed:

- **The Board of Medicine's fund reserves are currently adequate, but are projected to decline in fiscal year 2000, even with anticipated increases in revenue.**

The board should monitor revenue and expenditures and seek fee increases as necessary to meet the rising costs of case investigation.

As shown in Table 3.4, the board's fund balance declined each year in terms of months of operating reserve. We project the fund balance will decline in fiscal year 2000, despite recently approved fee increases. Should the board use its entire spending authority for fiscal year 2000, we estimate the board's fund balance would decline to $823,020 or about eight months of operating reserve. While this balance appears adequate for the present, the Board of Medicine should closely monitor revenues and expenditures and seek adjustment to its licensing fees as necessary to adequately meet the rising costs of case investigation and resolution.

[2] For fiscal years 1996–2000, the board received an additional $326,000 in enhancements and non-standard adjustments for non-discipline purposes.

Table 3.4: Board of Medicine Fund Balances, Fiscal Years 1996–2000

Fiscal Year	Fund Balance	Months of Operating Reserve[a]
1996	$924,200	20.6
1997	927,800	17.6
1998	902,096	15.3
1999	968,920	13.4
2000	823,020[b]	8.3

[a] Number of months the board could operate on its fund balance if no revenues were received.
[b] Projected data.

Sources: Office of Performance Evaluations analysis of Board of Medicine data and STARS data maintained by the Office of the State Controller.

Public Awareness and Participation in Board of Medicine Complaint Resolution Processes

Chapter 4

Idaho Code charges the Board of Medicine with administering the Medical Practice Act, the purpose of which is to assure public health, safety, and welfare through the licensure and regulation of physicians.[1] This involves, in part, providing the public with information about the board's role in regulating and disciplining licensees. We examined the potential impact of new legislation, the Patient Freedom of Information Act, that gives the Board of Medicine additional responsibilities related to providing the public with information about lawsuits and other actions against health care providers who are licensed by the board. We then looked at the board's efforts to ensure the public is aware of its complaint investigation and resolution functions. We also assessed the level of public involvement in the discipline case resolution process as indicated by public membership on the Boards of Medicine and Professional Discipline.

Legislation passed in 1998 gives the Board of Medicine new responsibilities to make disciplinary information about health care providers accessible to the public.

We conclude that although the Patient Freedom of Information Act will increase publicly available information about health care providers, it has weak enforcement provisions and may be only moderately effective in producing useful information about health care providers' practice histories. In addition, although the board has developed materials about its operations and maintains files on licensee discipline, it performs little or no public education or outreach, limiting public awareness of its role in investigating and resolving complaints about licensees. Finally, we conclude that the number of public members on the Boards of Medicine and Professional Discipline by law is about average for medical boards nationally.

[1] IDAHO CODE § 54-1803, -1808 (1998).

The Patient Freedom of Information Act

The Patient Freedom of Information Act requires the board to collect and maintain licensee information ranging from medical schools attended to criminal convictions for felonies.

In 1998, the Legislature passed the Patient Freedom of Information Act, codifying the requirement that health care provider historical profiles be accessible to the public. The act requires specified health care providers to self-report to the Board of Medicine certain information about their practice and history when obtaining or renewing a license, beginning in January 2000.[2] In turn, the act requires the Board of Medicine to collect and maintain reported information for the purpose of creating profiles for public review.[3] Figure 4.1 lists the information that Idaho Code requires to be reported and maintained.

According to board staff, once they have developed the mechanisms needed to record the information submitted, the profiles will be available to the public via the Internet and by telephone. The public will be able to access profiles by provider name or license number.

We reviewed profiling laws in Rhode Island and Massachusetts and interviewed medical board staff responsible for administering profiling systems in these two states and seven others, for a total of nine states. We compared Idaho's act with similar provisions in nine states. We also reviewed the Internet web sites for 19 states that provide profile information. We found:

The provisions for enforcing the act are weak.

- **The enforcement mechanisms in Idaho's Patient Freedom of Information Act are weak relative to those in similar laws in other states.**

A health care provider may be out of compliance with Idaho's act if he or she does not submit the required information or submits false information. In these cases, the board may fine a provider up to $50 per day and may take other disciplinary action—except action related to the provider's license—as deemed appropriate.

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[2] IDAHO CODE § 54-4601 (1998). The act specifies the following health care providers: medical doctors, osteopathic doctors, physician assistants, physical therapists, dentists, podiatrists, chiropractors, optometric physicians, psychologists, nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists.

[3] The Legislature appropriated approximately $106,000 in fiscal year 2000 to implement the new system.

Figure 4.1: Information Required to Be Self-Reported by Health Care Providers Under the Patient Freedom of Information Act

The Patient Freedom of Information Act requires health-care providers included in the act to self-disclose the following information at the time of initial licensure and upon license renewal:

- Names and addresses of medical/professional schools attended, and dates of graduation;
- Specialty certifications recognized by the board;
- Appointments to faculty of any medical/professional school and any responsibility for graduate education over the previous ten years;
- Location and type of practice for the most recent ten years;
- Current location of primary practice setting(s);
- Hospital(s) serving as provider's primary admitting facility and at which provider has active clinical privileges in good standing;
- Medicaid/Medicare participation and/or whether provider has ever been barred from either program;
- Any available translating services;
- Criminal convictions for felonies or other crimes "of moral turpitude" over the past ten years;
- Any final Board of Professional Discipline disciplinary actions over the last ten years considered public in accordance with Idaho Code;
- Any final medical board actions from other states within the most recent ten years;
- Any revocation or involuntary restriction of hospital privileges or a reduction in credentials for more than 180 days (includes resignation to avoid revocation or reduction);
- Whether provider carries medical malpractice insurance or if insurance has been denied;
- All malpractice court judgments and arbitration awards in which a payment was awarded to a complainant over the last ten years;
- Malpractice settlement claims if the provider had five or more in the past five years, each of which was $50,000 or more (or ten of any amount over the same period of time); and
- Percentage ownership in other facilities related to the provision of health care services to which the provider's patients are, have been, or may be referred.

Source: IDAHO CODE § 54-[46]4503 (1998).

However, these penalties for noncompliance are minimal relative to those allowed in seven of the nine other states we examined. Except for Colorado, every state we reviewed could impose larger fines and/or take disciplinary action up to and including license revocation for noncompliance.[4] For example, California can

[4] Although Colorado has a profiling system in place, the system is not required by law.

impose fines as high as $5,000 for failure to report a criminal conviction and $50,000 for failure to report a medical malpractice judgment. Through our review of web sites, we learned that Arizona, Oregon, Massachusetts, and Rhode Island each have a number of disciplinary actions that may be taken if a health care provider fails to comply with reporting requirements, up to and including license revocation. Providers in Massachusetts may be charged criminally for perjury if they provide false information.

Eight of nine states we examined had stronger enforcement mechanisms available.

Further, we found:

- **Idaho's Patient Freedom of Information Act may be only moderately effective in producing useful information for the public about health care providers' practice histories.**

Idaho's act states its purpose is to allow patients "to make more informed decisions about whom they wish to engage when in need of health care services."[5] However, our review of profiling laws in other states brought to light potential limits to the Idaho act's ability to accomplish this goal.

- **Idaho's profiling system will rely on self-disclosure by health care providers, while other states we reviewed rely on a combination of information sources.** Each of the state profiling systems we reviewed asked for information from selected health care providers, relying on self-disclosure to some extent. Nine state systems we reviewed also incorporated information reported from other sources, such as hospitals, insurance firms, and their own medical boards. For example, Rhode Island combines provider self-disclosed information with its medical board's disciplinary actions and data such as criminal convictions and insurance payments reported from other sources. Also, a representative of the Federation of State Medical Boards indicated that using multiple sources for a health care provider profiling system is typical amongst the 19 states with profiling systems.

Information in the system will be self-reported by licensees.

- **Idaho's act does not require board verification of self-reported information, while in other state systems we reviewed, the data, data sources, and collection methodologies are reviewed for quality and accuracy.** In Idaho, each provider who submits a profile must include a statement, signed under oath, attesting to the completeness

[5] IDAHO CODE § 54-[46]4501 (1998).

and correctness of the information it contains. However, the law specifically states the Board of Medicine will not verify the information submitted. According to statute, the profile is to be made available to the public with a disclaimer stating that it was self-disclosed by the provider and not verified by the Board of Medicine.[6] On the other hand, each of the state profiling systems we reviewed included data verification mechanisms. For example, the Massachusetts law requires the board to verify the data in two ways, by including other sources of information that can be verified independently and by evaluating the quality and accuracy of provider profiles, data sources, and methodologies regularly.

Unlike Idaho, each of the other state profiling systems we reviewed included mechanisms to verify the information submitted.

In light of the identified limitations to Idaho's Patient Freedom of Information Act:

Should policymakers wish to strengthen Idaho's health care provider profiling system, the statutory provisions for verification of reported data, sources of data, and board enforcement authority should be reviewed.

The Board of Medicine's Public Outreach

We also assessed the Board of Medicine's efforts to ensure the public is aware of its regulatory and complaint investigation and resolution functions. We surveyed similar boards in North Dakota, Oregon, Washington, and Wyoming and spoke with a representative of the Federation of State Medical Boards. We also surveyed the web sites for each of the 50 states, gathering information where available and reviewed recent reports from other states. We found:

We compared the board's efforts at public outreach with those in other states.

- **Although the Board of Medicine has developed educational materials about its operations related to licensee discipline, it otherwise takes few steps to inform the public about its role.**

The board publishes a pamphlet that describes medical malpractice, licensee discipline, what constitutes a violation of the Idaho Medical Practice Act, information to be included in a written complaint, and complaint and prelitigation screening

[6] IDAHO CODE § 54-4603(3) (1998).

processes.[7] The board also issues a semi-annual newsletter that lists all final public disciplinary actions taken by the Board of Professional Discipline during the previous year. However, both the pamphlet and newsletter are available only upon request and would not be available to someone unaware of the board's existence. Further, although the board publishes its phone number in the government section of phone books throughout the state and maintains a toll-free number for complaints or information requests, its web site is still being developed. Finally, the board maintains files regarding active licensees who have had final public disciplinary actions in Idaho. Although these files are kept separately from confidential case files so that the public may easily review them, few members of the public are aware they may do so.

Medical boards in other states we reviewed made greater efforts to inform the public about their roles.

We compared these outreach efforts with those in the other states we contacted or for which we gathered information from a web site or recent performance evaluation. We found:

- **Health regulatory boards in states we reviewed generally made stronger efforts to educate the general public about their role and the information they can provide about licensee discipline.**

In general, the medical boards we spoke with made greater effort to educate the public about their role in overseeing medical licensees. For example, the Colorado Board of Medical Examiners maintains a web site with information such as contact information, a description of physician misconduct, complaint filing directions, an electronic complaint form, and a link to their health care provider profiling system.

In Texas, all licensed physicians are required to notify patients of the Board of Medical Examiners' address and phone number on placards in the physician's practice, on the contract for health services, or on the patient's bill. The board also maintains a permanent Public Information Committee to respond to public information requests and evaluate the board's public relations. The board issues press releases when it takes disciplinary action

[7] As mentioned previously, prelitigation screening is a case review process that complainants must first complete when seeking redress through medical malpractice. It is designed to reduce frivolous civil suits and promote settlements.

that can be reported to the public and maintains a statewide toll-free number for public complaints or requests for information.

A number of medical boards maintain Internet web sites that assist the public in filing complaints.

In addition, many states use web sites to communicate their roles in licensee discipline. Medical boards in at least 40 states have a web site. Of these, 28 (70 percent) include information regarding how to initiate a complaint. In Kansas, for example, the web site includes an electronic complaint form that may be downloaded, directions for submitting the complaint, and a description of physician misconduct in lay terms. As noted, the Board of Medicine has not had a web site to date and it remains unclear what public outreach information will be included on the site that will be developed.[8]

Without this or other outreach efforts, members of the public may be unaware of the board's responsibility to investigate and resolve complaints about licensees. Members of the public may also be unaware of what constitutes physician misconduct and the recourse available should it occur. Therefore, given its statutory charge:

We recommend the Board of Medicine create a plan for improving public outreach and education about its role in licensee discipline.

The board should adopt innovative information exchange links from other medical board web sites.

Should the board choose to develop its web site for this purpose, the site should include information about both the Board of Medicine and the Board of Professional Discipline, be easy to access, and use lay terms to communicate relevant information. The board may also consider including a description of the complaint investigation and resolution process, directions for filing a complaint, and an electronic version of a complaint form that may be downloaded for use.

Public Membership on the Boards of Medicine and Professional Discipline

We also assessed the level of public involvement in the discipline case resolution process as indicated by public membership on the Boards of Medicine and Professional Discipline. We found:

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[8] Board of Medicine staff told us they are in the process of selecting a contractor to develop a web site.

- **The number of public members on the Boards of Medicine and Professional Discipline by law is about average for medical boards nationally.**

Public membership on Idaho's Board of Medicine and the Board of Professional Discipline is roughly comparable to other boards nationally.

Under Idaho Code, public members comprise 20 percent of each board. As described in Chapter 1, Idaho Code requires that two of the ten members of the Board of Medicine be public members, while one of five members of the Board of Professional Discipline must come from the public.[9] Public membership averages a comparable 22 percent nationally, according to data the Federation of State Medical boards collected in a survey of 68 medical boards.[10] Five boards had no public members, while members of the public made up 50 percent of one board.

Two recent performance evaluations of health profession regulatory agencies have been critical of boards with a large majority of board members from within the regulated profession. Arizona's Auditor General cited concerns that such regulatory boards had the potential for: conflicts of interest when disciplining a provider in the same profession, disregard for public input in regulatory matters, poor quality investigations, and large complaint backlogs.[11] The report further concluded that, in Arizona, these problems had undermined public confidence. Like the Arizona Auditor General, the Minnesota Office of the Legislative Auditor determined that increasing public membership of regulatory boards could increase public confidence in the disciplinary process.[12]

While some in other states have advocated increasing public membership it appears to be unnecessary in Idaho at present.

However, as shown in Chapter 2, it does not appear that the makeup of the Idaho Board of Medicine has resulted in lower than average rates of discipline or a large case backlog. Furthermore, we concluded that board staff had investigated the cases we reviewed in a consistent manner, regardless of complaint source. As a result, there appears to be little support for an increase in public membership on Idaho's boards at this time.

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[9] IDAHO CODE § 54-1805(2)(a), -1806A(1) (1998).
[10] Federation of State Medical Boards, *Exchange Database Survey Results* (March 1999).
[11] Arizona Auditor General, *The Health Regulatory System* (December 1995).
[12] Minnesota Legislative Auditor, *Occupational Regulation* (February 1999).

On the other hand, we observed that:

- **The terms of the public members on the Board of Medicine end simultaneously, which may not ensure continuity of public representation.**

The two public members on the Board of Medicine each began their first three-year term July 1, 1996 and were re-appointed for second (and final) terms this year.[13] According to our discussions with these and other board members, newly appointed public members have tended to participate less while they orient to membership on a technical board. As a result, public involvement in the board's processes can be interrupted during periods of transition.

Staggering the terms of public members on the Board of Medicine could help ensure consistent public representation.

The Board of Professional Discipline faces a similar limitation with only one public member. However, under Idaho Code, public members of the Board of Medicine may be appointed to the Board of Professional Discipline, allowing for the potential transfer of experience they have gained.[14] Also, according to board staff, it is the practice of members of the Board of Medicine to often attend Board of Professional Discipline meetings. This practice could further prepare a member for transition to the disciplinary board.

Given the time lag since the last new public member appointment, we did not assess the impact of the transition in membership on overall public involvement in the process. Should this be of interest, policymakers could monitor the matter for needed change in the future.

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[13] On the other hand, the four physician members on the Board of Professional Discipline serve staggered terms such that no more than two members' terms expire at the same time.

[14] IDAHO CODE § 54-1806A(1) (1998).

Response to the Evaluation

Idaho State Board of Medicine

PO Box 83720 Boise, ID 83720-0058

August 23, 1999

Nancy Van Maren, Director
Office of Performance Evaluations
J.R. Williams Building
Lower Level, Suite 10
PO Box 83720
Boise, ID 83720-0055

Dear Ms. Van Maren:

Thank you for the opportunity to comment on the report, *The State Board of Medicine's Licensee Complaint Resolution Process*, for the Joint Legislative Oversight Committee. The performance evaluation and its findings have provided the Board with an overall assessment of our complaint process. This will assist the Board in the refinement and improvement of our complaint process. The report's recommendations to the Board will be given serious study and consideration.

Also, the Board was appropriated funding this fiscal year for the final upgrade of our office computer system which includes a website. Our goal is to have the website operational no later than April 1, 2000. The report's recommendations for improving public outreach and education will be of important assistance in the design and development of our website.

Again, thank you for the opportunity to review and comment on the report.

Sincerely,

Darleene Thorsted

Darleene Thorsted
Executive Director

Telephone (208) 334-2822 Facsimile (208) 334-2801 Location: 280 N. 8th St., Ste 202

Completed Performance Evaluations

Publication Number	Report Title	Date Released
95-01	State Travel Management	August 1995
95-02	Medicaid Services for Children With Disabilities	November 1995
96-01	Safety Busing in Idaho School Districts	February 1996
96-02	Oversight of Pupil Transportation Contracts	February 1996
96-03	Use of Bus Routing Software in Idaho School Districts	May 1996
96-04	Contracted Versus District-Operated Pupil Transportation Programs: An Analysis of Cost and Program Differences	May 1996
96-05	State-Owned Dwellings	October 1996
96-06	Estimating and Reducing the Tax Gap in Idaho	December 1996
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98-02	Medicaid Reimbursement for Outpatient Occupational and Speech Therapy	June 1998
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98-04	Management Review of the Idaho Commission for the Blind and Visually Impaired	October 1998
99-01	The State Board of Pharmacy's Regulation of Prescription Controlled Substances	June 1999
99-02	The State Board of Medicine's Resolution of Complaints Against Physicians and Physician Assistants	October 1999
99-03	Employee Morale and Turnover at the Department of Correction	October 1999

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